Early Hearing Detection and Intervention Reporting Form

Iowa's Early Hearing Detection & Intervention Program

Initial hearing screening results must be reported within 6 days of the newborn's birth.

***Patient name (Last, First, MI) : M ___ F ___**	**Medical Record Number:**

Baby Demographics:

*Date of birth:
mo day yr
***Place of Birth**
(if different than above):

Gestational age:
weeks
Birth weight:
grams

Time of birth

Race/Ethnicity

Risk Factors:

- ☐ Assisted Ventilation
- ☐ Bacterial or Viral Meningitis
- ☐ Congenital CMV confirmed in baby
- ☐ Congenital Herpes confirmed in baby
- ☐ Congenital Rubella confirmed in baby
- ☐ Congenital Syphilis in baby
- ☐ Congenital Toxoplasmosis confirmed in baby
- ☐ Craniofacial anomalies
- ☐ ECMO
- ☐ Exchange transfusion for elevated bilirubin
- ☐ Family hx of childhood hearing loss
- ☐ Head Injury
- ☐ Neurodegenerative Disorder
- ☐ NICU > 5 days
- ☐ Other Congenital Infection
- ☐ Other postnatal infection
- ☐ Otitis media > 3 months (middle ear infection)
- ☐ Ototoxic medications administered
- ☐ Parental concern regarding hearing status
- ☐ Syndrome

Mother/Guardian Information:

*Name (Last, First, MI):

*Address:

*Phone numbers
(including area code):

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***Results:**

Technology used:	Result for Left Ear:	Result for Right Ear:
☐ DPOAE ☐ TEOAE ☐ AABR	☐ Pass ☐ Refer ☐ Not screened (list reason)	☐ Pass ☐ Refer ☐ Not screened (list reason)

Screening Location:

☐ Birth Admit
Screening date:
mo day yr
OR
☐ Outpatient
Screening date:
mo day yr

Screen performed by:
(screener's name)

*Newborn's primary care provider:
(name of infant's primary care provider)